| CENTERSTOR | WEDICAKE & WEDIC | AID SERVICES | | | OMB 110: 0750-0571 |
|------------|---|------------------------------|------------------|--|--------------------|
| STATEMEN | IT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CO | ONSTRUCTION | (X3) DATE SURVEY |
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | , DITH DDIG | 00 | COMPLETED |
| | | 155564 | A. BUILDING | | 07/08/2011 |
| | | | B. WING | | |
| NAME OF F | PROVIDER OR SUPPLIER | t | | ADDRESS, CITY, STATE, ZIP CODE | |
| | | | | EST HARRISON ST | |
| MILLER'S | S MERRY MANOR | | MOOR | ESVILLE, IN46158 | |
| (X4) ID | SUMMARY S | STATEMENT OF DEFICIENCIES | ID | | (X5) |
| PREFIX | (EACH DEFICIEN | ICY MUST BE PERCEDED BY FULL | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | COMPLETION |
| TAG | • | LSC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | DATE |
| F0000 | | • | | | |
| 1.0000 | | | | | |
| | This wisit was for | r the Investigation of | F0000 | The Mooresville facility | i |
| | This visit was for the Investigation of | | F0000 | respectfully requests paper | |
| | Complaint IN00 | 093118. | | compliance. Please accept | the |
| | | | | following plan of correction f | |
| | Complaint IN00 | 093118 - Substantiated. | | F-Tag 225 and F-Tag 226 as | |
| | • | iciencies related to the | | credible allegation of compli | |
| | | red at F225 and F226. | | · | |
| | anegation are cit | ed at 1223 and 1220. | | | |
| | | | | | |
| | Survey dates: Ju | aly 07 and 08, 2011 | | | |
| | | | | | |
| | Facility number: | 000398 | | | |
| | Provider number | | | | |
| | | | | | |
| | AIM number: 10 | 00291110 | | | |
| | | | | | |
| | Survey team: Ki | imberly Perigo, RN | | | |
| | | | | | |
| | Census bed type: | | | | |
| | SNF: 18 | • | | | |
| | | | | | |
| | SNF/NF: 51 | | | | |
| | Total: 69 | | | | |
| | | | | | |
| | Census payor typ | oe: | | | |
| | Medicare: 12 | | | | |
| | Medicaid: 40 | | | | |
| | | | | | |
| | Other: 17 | | | | |
| | Total: 69 | | | | |
| | | | | | |
| | Sample: 03 | | | | |
| | 1 | | | | |
| | Those deficient | as reflect state findings | | | |
| | These deficiencies reflect state findings | | | | |
| | cited in accordar | nce with 410 IAC 16.2. | | | |
| | | | | | |
| | Quality review com | pleted 7/11/11 by Jennie | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7NC011

Facility ID:

000398

TITLE

If continuation sheet

(X6) DATE

| l f | | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155564 | (X2) MULTIPLE CO A. BUILDING B. WING | NSTRUCTION 00 | (X3) DATE SURVEY COMPLETED 07/08/2011 |
|--------------------------|--|---|--|---|---------------------------------------|
| | PROVIDER OR SUPPLIER S MERRY MANOR | | STREET A | ADDRESS, CITY, STATE, ZIP CODE EST HARRISON ST ESVILLE, IN46158 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | (X5) COMPLETION DATE |
| F0225 SS=D | Bartelt, RN. The facility must in have been found gor mistreating residence have had a finding nurse aide registry mistreatment of resoftheir property; a has of actions by a employee, which we service as a nurse the State nurse aide authorities. The facility must eviolations involving abuse, including in and misappropriat reported immediate the facility and to with State law throst (including to the Sagency). The facility must halleged violations and must prevent the investigation is The results of all in reported to the addrepresentative and accordance with State survey and oworking days of the violation is verified action must be taken. | ot employ individuals who guilty of abusing, neglecting, dents by a court of law; or gentered into the State or concerning abuse, neglect, sidents or misappropriation and report any knowledge it a court of law against an awould indicate unfitness for aide or other facility staff to de registry or licensing Insure that all alleged genistreatment, neglect, or nijuries of unknown source ion of resident property are sely to the administrator of other officials in accordance ough established procedures tate survey and certification Insure that all alleged genistreatment, neglect, or nijuries of unknown source ion of resident property are sely to the administrator of other officials in accordance ough established procedures tate survey and certification Insure that all alleged genistreatment, neglect, or nijuries of unknown source ion of resident property are sely to the administrator of other officials in accordance ough established procedures tate survey and certification survey and certification for his designated of to other officials in the designated of the other officials in the certification agency) within 5 e incident, and if the alleged appropriate corrective ten. | F0225 | F- Tag 225 and F-Tag 226: | 08/07/2011 |
| | | rvation, interview, iew, the facility | F0225 | Investigate and Report Allegations/Individuals: It is policy of Miller's Merry Mano | s the |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE SURVEY | |
|--|--|------------------------------|------------|------------|--|-------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | LDING | 00 | COMPLETED |
| | | 155564 | B. WIN | | | 07/08/2011 |
| NAME OF I | DROWINED OF GUIDNI 1ED | <u>u</u> | <u> </u> | STREET A | ADDRESS, CITY, STATE, ZIP CODE | |
| NAME OF F | PROVIDER OR SUPPLIER | | | 259 WE | ST HARRISON ST | |
| MILLER'S | S MERRY MANOR | | | MOORE | ESVILLE, IN46158 | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | · | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | |
| TAG | | LSC IDENTIFYING INFORMATION) | - | TAG | Mooresville to ensure all | DATE |
| | | e a licensed nurse | | | allegations of abuse are repo | orted |
| | immediately removed a resident | | | | to the administrator of the fac | |
| | from a source | of alleged abuse and | | | and/or other officials in | |
| | assessed for in | jury for 1 of 2 | | | accordance with the State la through established procedu | l l |
| | | alleged violations of | | | The facility policy requires th | |
| | | nt abuse in a sample | | | alleged violations are thorou | |
| | | - | | | investigated, and the facility | |
| | | reviewed for use of a | | | prevent further potential abuse while investigation is in programme. | |
| | physical restra | int. (Resident A) | | | The results of all investigation | |
| | | | | | must be reported to the | |
| | Findings include: | | | | administrator or other design | ee |
| | | | | | and to other officials in accordance with State law. | , |
| | During initial: | tour on July 07, 2011, | | | written report will be complet | |
| | _ | | | | within 5 working days of incident | |
| | at 9:40 a.m., R | | | | and if the alleged violation is | |
| | · · · | g down in a low bed. | | | verified that appropriate | 44. |
| | A mat was pos | sitioned on the floor, | | | corrective action. Resident (who was not harmed) All | #A: |
| | beside the righ | nt and left side of the | | | allegations of abuse will be | |
| | bed. A one-ha | ılf side rail was | | | investigated; interventions | |
| | nositioned up | on the upper right | | | implemented immediately to | huaa |
| | 1 - | l. A grab bar was | | | prevent further or potential a and will be reported per facil | |
| | | • | | | abuse prohibition policy and | ., |
| | * * * * * * * * * * * * * * * * * * * | on the upper left side | | | procedure. (Attachment A: | |
| | of the bed. Re | esident A was awake | | | Abuse Prohibition, Reporting | |
| | and independe | ently moving about in | | | and Investigation, resident a LPN # 5: All residents are | · • |
| | the bed. | | | | risk to be affected by the def | l l |
| | | | | | practice. LPN # 5 was | |
| | Resident A's c | linical records were | | | disciplined, counseled, and | |
| | Resident A's clinical records were reviewed on July 07, 2011, at 1:45 p.m. | | | | educated on proper procedu LPN #1 was disciplined, | 169. |
| | | | | | counseled, and put on final r | notice |
| | | | | | for putting a sheet on the sid | e |
| | | | | | rail. As for the C.N.A., she w | |
| | A Side Rail As | ssessment dated June | | | counseled/ in-serviced along all other staff on proper abus | |
| | | | | | · · | |
| FORM CMS-2 | 2567(02-99) Previous Version | ons Obsolete Event ID: | 7NC011 | Facility l | ID: 000398 If continuation s | heet Page 3 of 19 |

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155564 07/08/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 259 WEST HARRISON ST MILLER'S MERRY MANOR MOORESVILLE, IN46158 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX COMPLETION PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE procedures. D.O.N. or designee 26, 2011, indicated, "Are side rails will monitor for any further of ANY type used on bed? Yes. reeducation needs/policy Type of rail(s) used? Half rails x changes. An all staff in-service will be held on 7/22/2011 by the [times] 2. Describe other: Upper facility administrator or other half rails to be used as enabler. designee to review the current policy for "Abuse Prohibition, Check all reasons why this type of Reporting, Investigation, resident side rail(s) is used: Enables abuse" procedures (Attachment A). Staff will be re-trained on the resident to reposition self in bed. importance of ensuring resident Enables resident to get in and/or out safety immediately upon any observation or report of alleged of bed assisted or independently. abuse. Any allegations of resident The resident has been determined to abuse will be immediately be safe with the rail(s) up by one or communicated to supervisor after ensuring residents safety. A more of the following: Able to use licensed nurse will complete a call light and request assistance into head to toe assessment and document any signs of harm or or out of bed. Does not attempt to injuries. If a staff member is climb over, around or through rails. involved in the allegation then the staff member will be suspended Notification form signed by and removed from the building resident or responsible party for use during the investigation process. of any type of side rails." In the event of resident to resident abuse the residents will be separated immediately and if The July 2011 Physician Orders needed will remain under direct supervision until the immediate indicated, "Ancillary Treatment investigation is complete and orders: ASSISTIVE DEVICE - 1 resident safety is maintained. All allegations will be promptly 1/2 side rail and 1 grab bar to be communicated to the used as enabler. 6/27/2011 [date administrator or other designee. It will be the responsibility of the order initiated]" Administrator, DON, or other designee to report any allegation/report of abuse to the A cognitive assessment dated July ISDH per facility policy and 03, 2011, indicated a score of 6 procedure via ISDH reporting

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155564 07/08/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 259 WEST HARRISON ST MILLER'S MERRY MANOR MOORESVILLE, IN46158 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE form and follow-up with a full [severe impairment]. Resident A investigation/report within 5 days was dependent on nursing staff for post the initial report. The facility daily decision making. will continue to complete monthly QA calls to resident families to also assist in monitoring the A functional status assessment ongoing quality of care provided to our residents. Abuse dated July 03, 2011, indicated educational information has been Resident A required extensive posted in various places throughout the facility such as assistance from nursing staff for the break room, employee activities of daily living. bathrooms, time clock for ongoing employee reference. facility will continue to provide The nursing schedule dated July 03, in-service training to all staff upon 2011, for Harrison Hall [unit new hire and at a minimum of twice a year regarding the facility Resident A resided] indicated LPN policies for "Abuse". The QA tool #1 and CNA #3 worked from 11:00 titled "Resident Satisfaction Review" (Attachment B) will be p.m. to 7:00 a.m. reviewed with residents during the monthly resident council meeting by social services or other On July 07, 2011, at 10:50 a.m., designee. Additionally, the CNA #3 was interviewed. During "Resident Satisfaction Review" will be completed with 3 resident the interview CNA #3 indicated per week for the next 4 weeks after initial rounds on July 03, then 3 residents per month for the 2011, LPN #1 reported having next 3 months to monitor compliance. We have also added positioned a sheet on and/or over a monthly QA tool (Attachment C) Resident A's right side rail, having as a system to monitor for abuse prevention for residents who are done this for resident's safety. At unable to make their needs around 4:00 a.m. to 4:30 a.m. CNA known. This tool will be completed 1 time per week for #3 entered the involved resident's the next 3 months then 1 time per room. No sheet was observed on month for the next 3 months. Any trends identified will result in either the side rail or the grab bar. immediate intervention/ Resident A was asleep with a sheet re-education and will be recorded

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) M | ULTIPLE CO | ONSTRUCTION | (X3) DATE : COMPL | | |
|--|----------------------|--|------------|---------------|--|---------|--------------------|
| ANDILAN | or connection | 155564 | - 1 | LDING | 00 | 07/08/2 | |
| | | | B. WIN | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF I | PROVIDER OR SUPPLIER | | | | EST HARRISON ST | | |
| MILLER' | S MERRY MANOR | | | MOORE | ESVILLE, IN46158 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) |
| PREFIX TAG | 1 | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ΤE | COMPLETION DATE |
| | and comforter | positioned on top of | | | on a QA log to be reviewed of | • | |
| | | uld normally sleep. | | | the monthly facility QA meeti | ng. | |
| | CNA #3 indica | ated not, at any time, | | | | | |
| | having observe | ed a sheet on either | | | | | |
| | the side rail an | d/or the grab bar of | | | | | |
| | Resident A's b | ed. | | | | | |
| | | | | | | | |
| | The nursing so | chedule dated July 04, | | | | | |
| | 2011, for Harr | ison Hall indicated | | | | | |
| | LPN #1 and C | NA #2 worked from | | | | | |
| | 11:00 p.m. to 7 | 7:00 a.m. | | | | | |
| | | | | | | | |
| | On July 07, 20 | 011, at 10:30 a.m. and | | | | | |
| | at 11:20 a.m., | CNA #2 was | | | | | |
| | interviewed. I | During the interview | | | | | |
| | CNA #2 indica | ated during initial | | | | | |
| | rounds on July | <i>'</i> | | | | | |
| | observed Resid | dent A to be asleep in | | | | | |
| | her bed. The r | right one-half side rail | | | | | |
| | was positioned | d up. A twin sheet | | | | | |
| | was tied to the | side rail at the top of | | | | | |
| | the top [having | g demonstrated the | | | | | |
| | upper most po | sition closest to the | | | | | |
| | | d] and to the top of | | | | | |
| | the bottom [ha | ving demonstrated | | | | | |
| | the upper most | t position closest to | | | | | |
| | middle of the l | bed]. The sheet was | | | | | |
| | observed to tra | evel from the side rail | | | | | |
| | to underneath | the comforter | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155564 | | LDING | NSTRUCTION 00 | (X3) DATE: COMPL 07/08/2 | ETED | |
|--|--|--|---------------------|---|------|----------------------------|
| | PROVIDER OR SUPPLIER | | 259 WE | ODDRESS, CITY, STATE, ZIP CODE ST HARRISON ST ESVILLE, IN46158 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | ATE | (X5) COMPLETION DATE |
| | positioned on a CNA #2 did not see in what point, under the coasked LPN #1 observation. If CNA #2 she has sheet like that, Resident A. Comfortable would and reported how LPN #5. On July 07, 20, #5 was interview LPN 04, 2011, she has a composed to the composition of the composit | top of Resident A. ot touch nor look to sition the sheet was omforter. CNA #2 | 1 | CROSS-REFERENCED TO THE APPROPRI | ATE | |
| | lying on her le one-half side r up. A twin she side rail at the [having demon most position of the bed] and to | be asleep in bed, ft side. The right ail was positioned eet was tied to the top of the top astrated the upper closest to the head of | | | | |

Facility ID:

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155564 | | | LDING | 00 | li i | E SURVEY PLETED (2011 | |
|--|---------------------|--|-------|--------|--|-----------------------------|------------|
| NAME OF | PROVIDER OR SUPPLIE | R | • | 1 | ADDRESS, CITY, STATE, ZIP CODI | E | |
| MILLER' | S MERRY MANOR | | | 1 | EST HARRISON ST ESVILLE, IN46158 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORREC | TION | (X5) |
| PREFIX | | NCY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR | LD BE | COMPLETION |
| TAG | + | R LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | 1 | osition closest to bed]. The sheet was | | | | | |
| | | ravel from the side rail | | | | | |
| | | op of Resident A." | | | | | |
| | | ated not having | | | | | |
| | | r to see how the sheet | | | | | |
| | | tioned. LPN #5 | | | | | |
| | _ | hought it looked like | | | | | |
| | | cradled around the | | | | | |
| | resident," hav | ing again indicated, "I | | | | | |
| | | o see the end of the | | | | | |
| | sheet." LPN | #5 then indicated | | | | | |
| | having left Re | esident A's room | | | | | |
| | without havin | g ensured the sheet | | | | | |
| | had been rem | oved nor having | | | | | |
| | assessed Resi | dent A for injury. | | | | | |
| | CNA #2 indic | eated to LPN #5, LPN | | | | | |
| | #1 untied and | removed the sheet. | | | | | |
| | | | | | | | |
| | 1 | 011, at 11:00 a.m., | | | | | |
| | | nterviewed. During | | | | | |
| | | LPN #1 indicated | | | | | |
| | _ | rounds on July 04, | | | | | |
| | | ered Resident A's | | | | | |
| | | erved her to be asleep | | | | | |
| | | ent A's arm had | | | | | |
| | 1 | gh the right side rail, | | | | | |
| | Resident A's o | done in the past. With | | | | | |
| | Resident A S | ognitive and | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155564 | | | LDING | NSTRUCTION 00 | (X3) DATE COMPL | ETED | |
|---|--|--|---------|---------------------|---|------|----------------------------|
| | PROVIDER OR SUPPLIER S MERRY MANOR | | P. 1111 | STREET A | ADDRESS, CITY, STATE, ZIP CODE SST HARRISON ST ESVILLE, IN46158 | ı | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | ATE | (X5) COMPLETION DATE |
| | assistance with #1 had position twin sheet to the then pulled it to sheet was positions side rail and the mattress, to proarm from goin potentially being On July 07, 20 time the involve was interviewed care were verbounded on July 08, 20 Resident A was #7. Resident A was #7. Resident A was present. No reson to complaints touching of Resident A's care were assessed. The asked of any conceptations assessed as the asked of any conceptations assessed. The asked of any conceptations assessed as the asked of any conceptations are the asked of any conceptations as the asked of any conceptations are the asked of any conceptations as the asked of any conceptations are the asked of any conceptations as the asked of any conceptations are the asked of any concepta | n ADL's status LPN ned, by having tied, a ne right side rail and oward the floor. The tioned between the ne right side of the event Resident A's g through the rail and ng hurt. 11, just after lunch oved resident's family ed. No concerns of halized. 11, at 1:25 p.m., s assessed by LPN A's family was edness, no bruising, | | | CROSS-REFERENCED TO THE APPROPRI | ATE | |
| | bed by use of a did not verbali | a sheet. The family ze any concerns and ything "is fine." | | | | | |

| | OF CORRECTION | IDENTIFICATION NUMBER: | | | NSTRUCTION 00 | | (X3) DATE: COMPL | |
|---------------|------------------------------------|--|-------------------|---------------|-------------------|---|---------------------|--------------------|
| | | 155564 | A. BUII B. WIN | | | | 07/08/2 | |
| MANUS OF S | an or an error | <u> </u> | D. WIN | | DDRESS, CITY, STA | TE, ZIP CODE | | |
| | PROVIDER OR SUPPLIER | | | | ST HARRISON | | | |
| MILLER' | S MERRY MANOR | | | MOORE | SVILLE, IN4615 | 58 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | | LAN OF CORRECTION E ACTION SHOULD BE | | (X5) |
| PREFIX TAG | • | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX TAG | CROSS-REFERENCE | ED TO THE APPROPRIATICIENCY) | ΓE | COMPLETION DATE |
| | The nursing fa | cility's Abuse | | | | | | |
| | Prohibition, R | * | | | | | | |
| | | Policy(s) dated | | | | | | |
| | August 23, 2010, provided by the | | | | | | | |
| | Administrator, indicated, | | | | | | | |
| | "POLICY: It is the policy of | | | | | | | |
| | | that all residents | | | | | | |
| | have the right | to be free from | | | | | | |
| | | e DEFINITIONS: | | | | | | |
| | abuse is defined as the willful | | | | | | | |
| | infliction of injury, unreasonable | | | | | | | |
| | confinement | . If resident abuse, or | | | | | | |
| | suspicion of al | buse is reported: a. | | | | | | |
| | The resident(s |) involved in the | | | | | | |
| | incident will b | e removed from the | | | | | | |
| | situation at on | ce. The Charge | | | | | | |
| | Nurse will exa | mine the resident(s) | | | | | | |
| | involved to de | termine if physical | | | | | | |
| | injuries have o | occured, and to their | | | | | | |
| | extent." | | | | | | | |
| | | | | | | | | |
| | On July 07, 20 | 011, at 3:30 p.m., the | | | | | | |
| | Administrator | and Director of | | | | | | |
| | Nursing were | interviewed. During | | | | | | |
| | the interview l | LPN #5's interview | | | | | | |
| | statement was | reviewed, which | | | | | | |
| | | lleged incident of | | | | | | |
| | | g unreasonably | | | | | | |
| | | or restrained Resident | | | | | | |
| FORM CMS 3 | 567(02-99) Previous Versio | ons Obsolete Event ID: | 7NC011 | Facility I | D: 000398 | If continuation sl | neet D- | ge 10 of 19 |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CO | | (X3) DATE SURVEY COMPLETED | |
|--|--------------------------------|--|------------------|--|--------------------|
| ANDILAN | or correction | 155564 | A. BUILDING | 00 | 07/08/2011 |
| | | | B. WING STREET A | ADDRESS, CITY, STATE, ZIP CODE |] |
| NAME OF F | PROVIDER OR SUPPLIER | | ı | EST HARRISON ST | |
| MILLER'S | S MERRY MANOR | | MOOR | ESVILLE, IN46158 | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | (X5) |
| PREFIX TAG | | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE COMPLETION DATE |
| | A with a sheet | while in bed, on the | | | |
| | night of July 04, 2011. LPN #5 | | | | |
| | | dicated having failed | | | |
| | to observe the | placement of the | | | |
| | sheet from the | right side rail, to | | | |
| | immediately re | emove Resident A | | | |
| | from the allege | ed restraint, and to | | | |
| | examine the re | esident to determine if | | | |
| | a physical inju | ry had occurred. The | | | |
| | administrative | staff, who were | | | |
| | present during | LPN #5's interview, | | | |
| | indicated LPN | #5 failed to | | | |
| | immediately re | emove an alleged | | | |
| | physical restra | int and assess the | | | |
| | resident for inj | jury. | | | |
| | | | | | |
| | | 11, the Administrator | | | |
| | _ | sciplinary Detail | | | |
| | dated July 08, | | | | |
| | | Detail indicated LPN | | | |
| | | sciplinary action for | | | |
| | _ | o remove a resident | | | |
| | _ | d physical restraint at | | | |
| | | ng failed to assess the | | | |
| | resident for inj | jury(s). | | | |
| | This fodoral to | a is related to | | | |
| | This federal ta | - | | | |
| | Complaint IN(| JUU73116. | | | |
| | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155564 | | | (X2) MULTIPLE CO A. BUILDING B. WING | 00 | (X3) DATE SUR' COMPLETE 07/08/2011 | D |
|--|--|---|--|--|--|---------------------------|
| | PROVIDER OR SUPPLIER | | 259 WE | ADDRESS, CITY, STATE, ZIP CODE EST HARRISON ST ESVILLE, IN46158 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE CC | (X5) OMPLETION DATE |
| F0226 SS=D | written policies an mistreatment, neg and misappropriat Based on observe record review, the a resident was in a source of allegoinjury as indicated Prohibition, Republicy(s) for 1 of violations of staff sample of 3 reside a physical restraint Findings included During initial tour 9:40 a.m., Reside down in a low be on the floor, beside of the bed. A on positioned up, or the bed. A grab the upper left side. | | F0226 | F- Tag 225 and F-Tag 226: Investigate and Report Allegations/Individuals:: It is policy of Miller's Merry Mano Mooresville to ensure all allegations of abuse are rep- to the administrator of the fa and/or other officials in accordance with the State la through established procedu. The facility policy requires the alleged violations are thorous investigated, and the facility prevent further potential abus while investigation is in proguent for the administrator or other designand to other officials in accordance with State law. written report will be comple within 5 working days of inci and if the alleged violation is verified that appropriate corrective action. Resident (who was not harmed) All allegations of abuse will be investigated; interventions implemented immediately to | s the or, orted cility w ures. eat all ghly must se ress. ons eee A ted dent | 8/07/2011 |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA | | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | | URVEY |
|---|---|--|---|--------|--|--|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | DING | 00 | COMPLE | ETED |
| | | 155564 | B. WIN | | | 07/08/20 |)11 |
| | | | B. WIIV | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF F | PROVIDER OR SUPPLIER | | | | EST HARRISON ST | | |
| MILLEDI | S MERRY MANOR | | | 1 | ESVILLE, IN46158 | | |
| IVIILLEN | S WERRT WANOR | | | WOOK | E3VILLE, IN40130 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | Resident A's clin reviewed on July A Side Rail Asse 2011, indicated, 'type used on bed used? Half rails other: Upper halenabler. Check a of side rail(s) is u reposition self in get in and/or out independently. It determined to be by one or more of use call light and or out of bed. Do over, around or the Notification form responsible party side rails." The July 2011 Phe "Ancillary Treated DEVICE - 1 1/2 be used as enable initiated]" A cognitive asses 2011, indicated a impairment]. Reserved. | ical records were 7 07, 2011, at 1:45 p.m. ssment dated June 26, "Are side rails of ANY ? Yes. Type of rail(s) x [times] 2. Describe f rails to be used as all reasons why this type used: Enables resident to bed. Enables resident to of bed assisted or The resident has been safe with the rail(s) up of the following: Able to request assistance into ones not attempt to climb | | | prevent further or potential a and will be reported per facil abuse prohibition policy and procedure. (Attachment A: Abuse Prohibition, Reporting and Investigation, resident at LPN # 5: All residents arrisk to be affected by the def practice. LPN # 5 was disciplined, counseled, and educated on proper procedu LPN #1 was disciplined, counseled, and put on final refor putting a sheet on the sid rail. As for the C.N.A., she we counseled/ in-serviced along all other staff on proper abuse procedures. D.O.N. or design will monitor for any further reeducation needs/policy changes. An all staff in-servill be held on 7/22/2011 by facility administrator or other designee to review the curre policy for "Abuse Prohibition Reporting, Investigation, residuse" procedures (Attachma). Staff will be re-trained on importance of ensuring residuse. Any allegations of residuse. Any allegations of residuse. Any allegations of residuse will be immediately communicated to supervisor ensuring residents safety. A licensed nurse will complete head to toe assessment and document any signs of harminjuries. If a staff member is involved in the allegation the staff member will be suspendent removed from the building and removed from the part and the process and removed from the building and removed from the staff member will be supported to the part and the process a | g, buse) e at icient res. notice e vas with se inee where ent the ent the ent sident after a or in the ded | |
| | | | | | and removed from the building | ٠.5 | |

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155564 07/08/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 259 WEST HARRISON ST MILLER'S MERRY MANOR MOORESVILLE, IN46158 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE during the investigation process. A functional status assessment dated July In the event of resident to 03, 2011, indicated Resident A required resident abuse the residents will extensive assistance from nursing staff for be separated immediately and if activities of daily living. needed will remain under direct supervision until the immediate investigation is complete and The nursing schedule dated July 03, 2011, resident safety is maintained. All for Harrison Hall [unit Resident A allegations will be promptly resided] indicated LPN #1 and CNA #3 communicated to the worked from 11:00 p.m. to 7:00 a.m. administrator or other designee. It will be the responsibility of the Administrator, DON, or other On July 07, 2011, at 10:50 a.m., CNA #3 designee to report any was interviewed. During the interview allegation/report of abuse to the CNA #3 indicated after initial rounds on ISDH per facility policy and procedure via ISDH reporting July 03, 2011, LPN #1 reported having form and follow-up with a full positioned a sheet on and/or over Resident investigation/report within 5 days A's right side rail, having done this for the post the initial report. The facility will continue to complete monthly resident's safety. At around 4:00 a.m. to QA calls to resident families to 4:30 a.m. CNA #3 entered the involved also assist in monitoring the resident's room. No sheet was observed ongoing quality of care provided on either the side rail or the grab bar. to our residents. Abuse Resident A was asleep with a sheet and educational information has been posted in various places comforter positioned on top of her, as one throughout the facility such as would normally sleep. CNA #3 indicated the break room, employee not, at any time, having observed a sheet bathrooms, time clock for ongoing on either the side rail and/or the grab bar employee reference. The facility will continue to provide of Resident A's bed. in-service training to all staff upon new hire and at a minimum of The nursing schedule dated July 04, 2011, twice a year regarding the facility for Harrison Hall indicated LPN #1 and policies for "Abuse". The QA tool titled "Resident Satisfaction CNA #2 worked from 11:00 p.m. to 7:00 Review" (Attachment B) will be reviewed with residents during the monthly resident council meeting On July 07, 2011, at 10:30 a.m. and at by social services or other designee. Additionally, the 11:20 a.m., CNA #2 was interviewed.

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | NSTRUCTION | (X3) DATE SURVEY | | | |
|--|--|----------------------------|--------------|------------|------------------|--|---------|-------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBE | ER: | A. BUIL | DING | 00 | COMPI | |
| | | 155564 | | B. WINC | | | 07/08/2 | 011 |
| NAME OF E | PROVIDER OR SUPPLIER | | | \Box | STREET A | ADDRESS, CITY, STATE, ZIP CODE | • | |
| | | | | | | ST HARRISON ST | | |
| MILLER'S | S MERRY MANOR | | | | MOORE | ESVILLE, IN46158 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENC | CIES | Γ' | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | `` | CY MUST BE PERCEDED I | |] | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | ΤE | COMPLETION |
| TAG | | LSC IDENTIFYING INFOR | | | TAG | DEFICIENCY) | | DATE |
| | " | view CNA #2 indica | | | | "Resident Satisfaction Revie will be completed with 3 resi | | |
| | ~ | nds on July 04, 201 | * | | | per week for the next 4 week | | |
| | | nt A to be asleep in | | | | then 3 residents per month f | | |
| | _ | ne-half side rail was | | | | next 3 months to monitor | | |
| | 1 ^ ^ | twin sheet was tied | | | | compliance. We have also a | | |
| | | e top of the top [hav | • | | | a monthly QA tool (Attachme as a system to monitor for al | | |
| | demonstrated the | upper most positio | n | | | prevention for residents who | | |
| | closest to the hea | d of the bed] and to | the | | | unable to make their needs | | |
| | top of the bottom | [having demonstra | ited | | | known. This tool will be | | |
| | the upper most po | osition closest to m | iddle | | | completed 1 time per week f | | |
| | of the bed]. The | sheet was observed | to | | | the next 3 months then 1 tim month for the next 3 months | • | |
| | travel from the si | de rail to underneat | th the | | | trends identified will result in | • | |
| | comforter positio | oned on top of Resid | lent | | | immediate intervention/ | | |
| | A. CNA #2 did | not touch nor look | to see | | | re-education and will be reco | | |
| | in what position t | the sheet was in, un | der | | | on a QA log to be reviewed of | | |
| | 1 1 | NA #2 asked LPN | | | | the monthly facility QA meet | ng. | |
| | | ation. LPN #1 indi | | | | | | |
| | | ad positioned the sh | | | | | | |
| | | safety of Resident A | | | | | | |
| | | comfortable with w | | | | | | |
| | | reported her observ | | | | | | |
| | to LPN #5. | reported ner observ | ation | | | | | |
| | to Li iv #3. | | | | | | | |
| | On July 07 2011 | , at 2:55 p.m., LPN | #5 | | | | | |
| | 1 1 | During the intervi- | | | | | | |
| | | d on July 04, 2011, | | | | | | |
| | | dent A's room, due | | | | | | |
| | _ | ne room by CNA #2 | | | | | | |
| | · · | e room LPN #5 obs | | | | | | |
| | - | asleep in bed, lying | | | | | | |
| | | | | | | | | |
| | her left side. The right one-half side rail was positioned up. A twin sheet was tied | | | | | | | |
| | | | s ilea | | | | | |
| to the side rail at the top of the top | | | | | | | | |
| | [[naving demonstr | rated the upper mos | ST. | | | | | |
| FORM CMS-2 | 2567(02-99) Previous Version | ns Obsolete | Event ID: 7N | C011 | Facility I | ID: 000398 If continuation s | heet Pa | ge 15 of 19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | IXI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ULTIPLE CO LDING | 00 | COMPI | |
|--|--|--|--------|---------------------|---|---------|------|
| | | 155564 | B. WIN | | | 07/08/2 | 011 |
| AVAILE OF PROJECT OF COURT AND | | | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF PROVIDER OR SUPPLIER | | | | 259 WE | ST HARRISON ST | | |
| MILLER'S MERRY MANOR | | | | MOORE | ESVILLE, IN46158 | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL | | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | | | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | |
| TAG | REGULATORY OR LSC IDENTIFYING INFORMATION) | | + | TAG | DEFICIENCI) | | DATE |
| | 1 ^ | to the head of the bed] | | | | | |
| | 1 ^ | f the bottom [having | | | | | |
| | | e upper most position | | | | | |
| | | e of the bed]. The sheet | | | | | |
| | | travel from the side rail | | | | | |
| | _ | of Resident A." LPN #5 | | | | | |
| | | ving looked further to see | | | | | |
| | | ad been positioned. LPN | | | | | |
| | | thought it looked like the | | | | | |
| | sheet was cradled around the resident," | | | | | | |
| | having again indicated, "I did not look to | | | | | | |
| | | e sheet." LPN #5 then | | | | | |
| | indicated having left Resident A's room | | | | | | |
| | without having ensured the sheet had been | | | | | | |
| | removed nor having assessed Resident A | | | | | | |
| | for injury. CNA | x #2 indicated to LPN #5, | | | | | |
| | LPN #1 untied and removed the sheet. | | | | | | |
| | On July 07, 2011, at 11:00 a.m., LPN #1 | | | | | | |
| | was interviewed. During the interview | | | | | | |
| | LPN #1 indicated during initial rounds on | | | | | | |
| | July 04, 2011, she entered Resident A's | | | | | | |
| | room and observed her to be asleep in | | | | | | |
| | bed. Resident A's arm had slipped | | | | | | |
| | through the right side rail, which it had | | | | | | |
| | done in the past. With Resident A's | | | | | | |
| | cognitive and assistance with ADL's status | | | | | | |
| | LPN #1 had positioned, by having tied, a | | | | | | |
| | twin sheet to the right side rail and then | | | | | | |
| | pulled it toward the floor. The sheet was | | | | | | |
| | positioned between the side rail and the | | | | | | |
| | 1 ^ | mattress, to prevent | | | | | |
| | Resident A's arm from going through the | | | | | | |
| | rail and potentially being hurt. | | | | | | |
| | 1 1 | , , | | | | | |

PRINTED: 08/04/2011 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCE AND PLAN OF CORRECTION | S (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155564 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 07/08/2011 | | | | |
|---|--|---|---------------------------------------|--|--|--|--|
| NAME OF PROVIDER OR SUF | | STREET ADDRESS, CITY, STATE, ZIP CODE 259 WEST HARRISON ST MOORESVILLE, IN46158 | | | | | |
| PREFIX (EACH DEF | RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PERCEDED BY FULL VOR LSC IDENTIFYING INFORMATION | ID PROVIDER'S PLAN OF CORR PREFIX (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AFT TAG | OULD BE COMPLETION PROPRIATE | | | | |
| On July 07, involved resinterviewed verbalized. On July 08, was assessed family was purising, no touching of The family concerns reland/or alled confinment The family and indicate The nursing Reporting, a dated Augus Administration and the policy of residents has physical abuabuse is definity, unreastedent abuareported: a. the incident situation at a examine the determine if | COR LSC IDENTIFYING INFORMATION) 2011, just after lunch time the dent's family was No concerns of care were 2011, at 1:25 p.m., Resident A by LPN #7. Resident A's resent. No redness, no complaints of pain upon desident A had been assessed. The resident A's care red restraint and/or to the bed by use of a sheet. The did not verbalize any concerns reverything "is fine." 2011, at 1:25 p.m., Resident A's resent. No redness, no complaints of pain upon desident A had been assessed. The resident A's care red restraint and/or to the bed by use of a sheet. The concerns reverything "is fine." 2011, at 1:25 p.m., Resident A's resent. The cheen sheet assessed and the resident and the r | TAG DEFICIENCY) | DATE | | | | |

| | T OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155564 | ĺ | LDING | NSTRUCTION 00 | (X3) DATE COMPL | ETED |
|--|--|---|---|---------------------|--|-----------------|----------------------------|
| NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR | | | STREET ADDRESS, CITY, STATE, ZIP CODE 259 WEST HARRISON ST MOORESVILLE, IN46158 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | .ΤΕ | (X5) COMPLETION DATE |
| | Administrator ar were interviewed LPN #5's intervireviewed, which incident of LPN confined and/or with a sheet while July 04, 2011. Lindicated having placement of the rail, to immediate from the alleged the resident to de injury had occur staff, who were printerview, indicated appropriately improhibition police. On July 08, 2011 provided a Disci 08, 2011. The Drindicated LPN # action for having Abuse Prohibition Police 2010. | d. During the interview ew statement was indicated an alleged #1 having unreasonably restrained Resident A le in bed, on the night of PN #5 then further failed to observe the sheet from the right side ely remove Resident A restraint, and to examine etermine if a physical red. The administrative present during LPN #5's ted LPN #5 failed to plement their abuse y(s). The Administrator plinary Detail dated July pisciplinary Detail dated July pisciplinary Detail for received disciplinary g violated the facility's en, Reporting, and licy(s) dated August 23, its related to Complaint | | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155564 | (X2) MULTIPLE CO A. BUILDING B. WING | 00 | | e survey Pleted 1/2011 | | |
|--|----------------|---|---|--|------------------------------------|------------------------------|--|--|
| NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR | | | STREET ADDRESS, CITY, STATE, ZIP CODE 259 WEST HARRISON ST MOORESVILLE, IN46158 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY) | RECTION HOULD BE APPROPRIATE | (X5) COMPLETION DATE | | |
| | 3.1-28(a) | | | | | | | |
| | | | | | | | | |